COLORECTAL CANCER SCREENING RESOURCES IN RHODE ISLAND

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There is essentially universal agreement that timely and appropriate colorectal screening can detect and remove precancerous polyps and/or detect colon cancer in an early, curative stage. In a previous survey,[1] the Rhode Island Cancer Council found that there was uniform agreement of the gastroenterologists and surgeons who perform endoscopy and the primary care physicians that colonoscopy was the preferred procedure for colorectal cancer screening (the gold standard). Currently, approximately 50% of the population over the age of 50 have not had any test for colorectal cancer whatsoever. Some concern was expressed that if a major educational program were to increase the number of individuals seeking colorectal cancer screening, resources within the State might be overwhelmed. Accordingly the Rhode Island Cancer Council undertook a survey of the endoscopists in the State, which sought information concerning the capacity of current resources and its utilization. A second survey was performed to determine the length of time it would take to schedule an endoscopy appointment.

Sixty-eight questionnaires were sent out to endoscopists we could identify in Rhode Island. Forty-two (62%) were returned. Ninety percent of the respondents have experienced an increase in referrals/requests for colonoscopy in the last year. They reported that 80% of the patients are aware of their status as either a standard risk or being at high risk for colon cancer and they reported that 33% of the procedures resulted in finding some abnormality. (Table 1)

On average, the responding endoscopists reported performing 75 procedures per month. They indicated that they believe their practices could accommodate approximately twice the number that they are performing.

The endoscopists reported that they all performed endoscopy examinations in a hospital endoscopy suite. In addition, a third of the endoscopists also utilized a dedicated freestanding endoscopy suite and only 10% performed endoscopies in their office suites. At no site did they report that the demand exceeded the capacity for performing colonoscopy.

On the basis of these data, an increase in the number of educational programs to improve the number of Rhode Islanders seeking this cancer screening examination can move forward without concern of overwhelming our capacity. In fact, expansion of endoscopy suites is planned at two hospitals, at least, at this particular time. The availability of time that endoscopists can devote to colonoscopy may be a limiting factor in expanding the number of procedures performed. Another limiting factor may be the number of female endoscopists since many women would prefer being examined by a female endoscopist. As in most other disciplines in Rhode Island, recruiting new physicians remains a serious impediment to the delivery of health care. The Rhode Island Cancer Council is investigating other barriers to patient participation in screening colonoscopy.

Since our data would indicate that the State of Rhode Island has adequate facilities for endoscopy, we wished to determine how soon a procedure could be schedule by an individual seeking referral to an endoscopists. We contacted 68 individual endoscopy offices with the following scenarios:

Scenario A

A 63 year old woman with a family history of colon cancer (her father). She has never had any procedure before. She went to the emergency room because she thought she had the flu. The emergency room physician, after taking care of her acute problem, also recommended to her that she should seek an appointment for colonoscopy.

Scenario B

A 55 year old man who, on routine physical examination, was found to have a positive fecal occult blood test. He had never had a colonoscopy before.

Table 1.

Questions	Yes	No
Increase in colonoscopies?	90.5%	9.5%
Are patients aware of risk status?	79.7%	20.3%
Colonoscopies resulting in abnormalities?	32.9%	67.1%

Scenario C

A 70 year old man in good health with no family history of colon cancer. He was convinced by his children that this was an important test that he should have performed.

Scenario A results indicated that a person calling could have a scheduled colonoscopy within 1 month in 52% of the offices, within 2 months in 67% of the offices, and within 3 months for 97% of the offices.

For *Scenario B*, 41% of the offices could schedule an examination within a month and 52% of the offices would schedule him within 6 weeks; 98% of the offices would schedule him within 3 months.

For *Scenario C*, 78% of the offices could schedule an examination within 1 month and 95% of the offices would schedule an examination within 2 months.

On the basis of these surveys, Rhode Island currently has adequate facilities for performing colonoscopy and individuals seeking this screening procedure would not experience an undue delay. (Table 2)

Table 2.

Time to Colonoscopy

	1 month	2 months	3 months
Scenario A	52%	67%	97%
Scenario B	41%	52%	98%
Scenario C	78%	96%	

References

1. Glicksman AS. Screening for colorectal cancer in Rhode Island. *Med & Health/RI* 2002; 85: 14-6

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Judicial Diagnosis

First-Ever HIPAA Conviction Highlights Differing Views of HIPAA's Civil and Criminal Penalties

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On November 5, 2004, Richard Gibson, a former cancer clinic employee, was sentenced to sixteen months in federal prison after pleading guilty to violating the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Prior to sentencing, Gibson admitted to disclosing the "protected health information" (PHI) of one of the clinic's patients. Gibson confessed to obtaining a cancer patient's PHI, including the patient's name, date of birth, and social security number, and disclosing the information to obtain credit cards in the patient's name. Gibson then used the credit cards to purchase thousands of dollars worth of various items for his personal use.

This conviction, the first ever under the privacy provisions of HIPAA, raises concerns about the diverging HIPAA enforcement theories held by the two federal agencies charged with enforcing HIPAA's privacy provisions. The Gibson conviction also puts physicians (and anyone else who handles confidential patient information) on notice that the field of possible targets for a government enforcement action under HIPAA is much broader than originally thought. That field now includes persons and entities not initially presumed to be covered by HIPAA.

HHS and DOJ Interpret the Term "Person" in HIPAA Differently

To understand the significance of the Gibson conviction, one must look to the source of HIPAA penalties: the statutory provisions that establish the government's ability to punish, either civilly or criminally, violations of HIPAA's privacy requirements. Both the civil and criminal provisions of HIPAA allow for the imposition of penalties against any "person" who violates HIPAA's privacy provisions.[1] While the use of an identical word ("person") in both provisions to define the object of potential penalties would seem to suggest that civil and criminal penalties could only be imposed against the same class or type of violators, this is not the case. The United States Department of Health and Human Services (HHS), the federal agency charged with enforcement of HIPAA's civil penalty provisions, and the Department of Justice (DOJ), the federal agency charged with enforcement of HIPAA's criminal penalty provisions, interpret the term "person" differently.

When the HIPAA Privacy Rule[2] was first published, HHS made clear that it interpreted the term "person" narrowly. HHS stated that it only had authority to impose civil penalties against "covered entities."[3] According to HHS' interpretation, only "covered entities" (CEs) fall within the definition of the term "person" as it appears in the HIPAA civil penalty statute. As a result, only CEs are subject to civil penalties. CEs include health plans (i.e., insurance companies and plans, Medicare and Medicaid contractors, and government agencies that pay for health care), clearinghouses (entities that convert electronic health care data from one format to another for billing or other purposes), and health care providers who electronically transmit